Addressing Urban Health in Detroit, New York City, and Seattle Through Community-Based Participatory Research Partnerships

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Objective. This study describes key activities integral to the development of 3 community-based participatory research (CBPR) partnerships.

Methods. We compared findings from individual case studies conducted at 3 urban research centers (URCs) to identify crosscutting adaptations of a CBPR approach in the first 4 years of the partnerships' development.

Results. Activities critical in partnership development include sharing decision-making, defining principles of collaboration, establishing research priorities, and securing funding. Intermediate outcomes were sustained CBPR partnerships, trust within the partnerships, public health research programs, and increased capacity to conduct CBPR. Challenges included the time needed for meaningful collaboration, concerns regarding sustainable funding, and issues related to institutional racism.

Conclusions. The URC experiences suggest that CBPR can be successfully implemented in diverse settings. (*Am J Public Health.* 2003;93:803–811)

In 1995 the Centers for Disease Control and Prevention (CDC) established 3 urban research centers (URCs) for applied research in public health in Detroit, New York City, and Seattle.[1] The mission of the URCs is to improve the health and quality of life of urban residents by developing, testing, and promoting effective interventions to address local health priorities. A key aim of the URCs is to develop innovative approaches to urban health problems by creating partnerships of community members, community-based organizations, community leaders, academic institutions, local health departments, the CDC, and other private and public organizations for the purpose of conducting community-based participatory research (CBPR).[2,3]

At the time the URCs were established, the CDC considered that participation of community partners was essential because of recognition that mistrust of researchers by communities of color could potentially limit future public health research in these communities.[3–5] In CBPR, researchers and community participants seek to collaborate as full partners in every phase of the research process: from the definition of the problem to be investigated; through the design, implementation, and evaluation of the intervention; to the dissemination of study findings.[6–18] A primary goal of CBPR is to increase a community's capacity to address and solve its own problems through the development of effective and sustainable interventions. Although the intent of CBPR is to improve capacity and increase resources within a community, the approach is not without potential problems for the community or other partners. The extensive time and effort required to conduct CBPR can place additional strain on already overtaxed community organizations. In addition, concerns have been raised about the distribution of power and other resources among community, academic, and agency partners.[19,20] For their part, researchers and funders interested in CBPR lack models, skills, and policies for power sharing, as well as increased time for developing and conducting participatory processes and practices.

The URCs were funded and began their work in this larger context. In the first phase of the URCs, 1995 to 1999, the CDC awarded noncategorical (i.e., non–disease-specific) core operating funds and provided an on-site CDC researcher to institutions for the purpose of establishing multisectoral partnerships (Table 1) and defining local health priorities in low-income communities, primarily those including African Americans, Latinos, Asians, Pacific Islanders, and multiple immigrant and refugee populations. (Because of CDC funding constraints, the New York City URC did not receive core funding in the first phase but did receive two CDC researchers. Core funding was awarded to New York City in 1999.)

Each URC was expected to supplement the CDC core awards with additional funding for research projects designed to address locally defined health concerns.

Although the theoretical rationale and expected benefits of the collaborative approach to CBPR have been extensively discussed, the literature is sparse on the application of this model to locally defined health priorities in urban settings. In this article, we describe key activities in the development of 3 urban community-based research partnerships and intermediate outcomes (Figure 1). Next, we describe common challenges experienced across the URCs during this developmental phase. Finally, we assess the relevance of CBPR partnerships to achieving public health goals.

METHODS

This article is based on ongoing evaluation activities conducted at each URC from 1995 to 1999. In 1999, a team of community partners and evaluators from the 3 URCs and the CDC assembled to conduct a multiple-site case study evaluation[21] of the 3 URCs. Community collaboration principles adopted by all 3 sites informed this self-evaluation. Members of the evaluation team

TABLE 1—The Urban Research Centers, 1995–1999

	Detroit	New York City	Seattle
Partnership name	The Detroit Community-Academic Urban Research Center	The Center for Urban Epidemiological Studies	Seattle Partners for Healthier Communities
Communities	Eastside and Southwest Detroit	Central and East Harlem	Central and South Seattle
Partners	· Butzel Family Center · Community Health and Social Services · Friends of Parkside · Kettering/Butzel Health Initiative · Latino Family Services · Warren/Conner Development Coalition · Detroit Health Department · Henry Ford Health System · Centers for Disease Control and Prevention · University of Michigan School of Public Health[a]	· Metropolitan Hospital Center · Project Return Foundation, Inc. · Settlement Health · The Riverside Church · Mount Sinai New York University Health · Veritas Treatment Center · Union Settlement · Harlem East Life Plan · Legal Aid Society · Central Harlem HIV Care Network · St. Christopher Inc. · Latino Organization for Liver Awareness · Mount Sinai School of Medicine · Mount Sinai Medical Center · Association for Drug Abuse Prevention and Treatment, Inc. · Incarcerated Mothers · Hunter College · New York Harm Reduction Educators · East Harlem Neighborhood Alliance · Children's Aid Society · Harlem United Community Health · Violence Intervention Program · HIV Law Project · STEPS (Self-help Training Education Prevention Services) to End Family Violence · Little Sisters of the Assumption · Centers for Disease Control and Prevention · New York Academy of Medicine[a]	· Healthy Homes · University of Washington Hospital, School of Public Health, School of Nursing · Cross-Cultural Health Care Program · Odessa Brown Community Clinic · Sea Mar Community Health Center · Rainier Beach Community Center · Community Activists · Seattle Community Public Health and Safety Network · Intergenerational Community Association · Puget Sound Neighborhood Health Centers · Asian Counseling and Referral Services · Campfire Boys and Girls Club · Central Area Health Care Center · Center for Multicultural Health · Central Area Senior Center · Community House Calls · Group Health Center for Health Promotion · International District Housing Alliance · Minority Health Coalition · Minority Youth Health Project · Seattle Urban Health Alliance · Somali Community Services of Seattle · United Way of King County · Centers for Disease Control and Prevention · Seattle-King County Dept of Public Health[a]

[a] Host institution.

collected field notes, surveys, board meeting minutes, grant proposals, and progress reports. Semistructured interviews were conducted with 51 people (23 URC investigators and staff and 28 community or institutional partners) across the sites. We coded and analyzed the semistructured interviews by standard qualitative data analysis methods,[22] and prepared individual case-study reports for each URC; the methods and results of these case-study reports are described elsewhere.[23–25] We compared findings from the individual case studies to identify common themes and site-specific adaptations to the CBPR approach in the first 4 years of implementation of the URCs.

RESULTS

Key Activities of Partnership Development

A shared goal of the URCs is to develop partnerships in which all stakeholders share in all aspects of the research. To facilitate this, each site developed its own URC board comprising community, academic, public health, and other partners. The URC boards seek to function not as advisory bodies to university or health department researchers but as full partners throughout the research process.

The URCs share a commitment to CBPR, but the implementation of that commitment has been shaped by a complex array of factors. Because of different funding constraints, local priorities, and methodological approaches, the URC partnerships have developed and progressed at different paces. Cross-site evaluation results suggest that despite such differences, several activities were critical in the development of partnerships at each URC. Key activities included sharing decisionmaking, defining principles of collaboration, establishing research priorities, and securing funding.

Sharing Decisionmaking

Early in their histories, all 3 URCs addressed questions of structure and governance, resulting in the adoption of formal bylaws or ground rules for shared decisionmaking. In broad strokes, the sites appear similar: decisions regarding oversight, budget, grant applications, selection of projects for funding, and hiring staff were made by all partners. The differences rest in the details, including who sits on the board, the stability of membership, and how votes are counted.

Each URC board comprises representatives from both private- and public-sector organizations, including academia, community-based organizations, and local health departments. In addition, the Detroit URC board includes a representative from a managed care organization, and the Seattle URC board includes individual community activists not associated with organizations. The URCs differ in terms of how board membership is determined. The Detroit URC has remained closed, including only the original member organizations se-

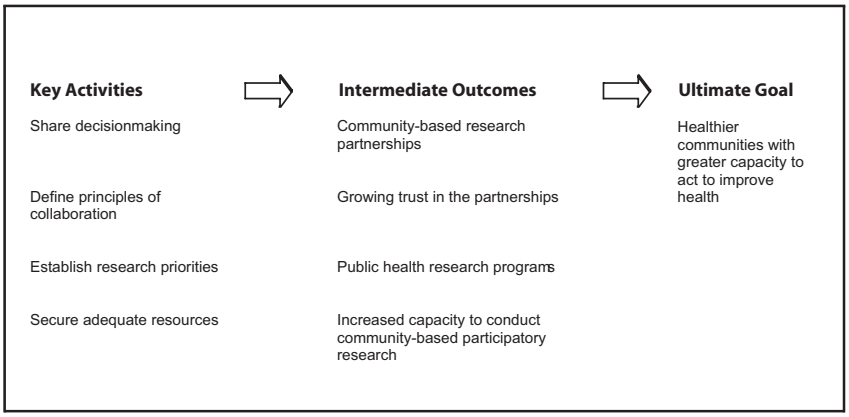

Figure 1—Development of urban research center community-based partnerships.

lected at the formation of the URC, whereas the other 2 URCs have open membership, allowing all interested persons to join. The inclusion of paid URC staff in board membership varies by site—the Detroit and Seattle URCs consider certain paid staff to be members of the board; the New York City URC does not.

Voting procedures also differ by site. At the Detroit URC, each represented organization has 1 vote, although broad consensus typically has been achieved through discussion, with very few decisions having been brought to a formal show of hands. At the Seattle URC, board bylaws restrict voting privileges to members who have attended 9 of the last 12 board meetings and who are active on at least 1 board committee. Although each eligible person has a vote, voting requires a quorum of at least 5 board members, a majority of whom must not be paid by the URC. The New York City URC allows all board members present at a meeting to vote.

Defining Principles of Collaboration

All URCs developed agreed-upon principles outlining how to collaborate as true partners in research activities. Community-based organizations and community members were interested in having new interventions, programs, and resources in their neighborhoods. However, they did not want to be studied as "subjects." Researchers were interested in assessing the effects of new interventions in the community. Principles of collaboration were developed to ensure balance between the desire for new interventions and services in a community and the desire to understand their impact. The principles provided criteria by which to gauge whether agreements about conducting the work of the partnerships were upheld.

The principles of collaboration reflect shared values, such as collaboration between researchers and nonresearchers in all phases of operations; open, clear, and respectful communication; and the conduct of research that directly serves participating communities by developing community capacity and ensuring the sustainability of effective interventions. For all URCs, common issues addressed in the principles included affirming the purpose of the research, enhancing community capacity to participate in research, collecting and managing data, disseminating findings, and adhering to human subjects review processes (Table 2).

The principles of collaboration guide the URCs in several ways. For example, the Detroit URC principles,[26] developed through an iterative process conducted at board meetings, are used to help board members make decisions about what types of projects to undertake. The Detroit and Seattle URC structures also include project-specific independent steering committees that focus on different content issues and expand links to the community by including additional organizational and community partners. Steering committee members use the principles to guide the research process to ensure that community knowledge and expertise are used and that the process is participatory in all phases. As noted by one Detroit URC community partner, "Academic types are used to a lot of control. [Our approach] creates a lack of control, and it takes a lot of time at every step of the way. It takes time if we are really going to follow the principles."

TABLE 2—Principles of Collaboration[a]

1. Participatory research is conducted through a collaboration of community members, community-based organizations, public health agencies, health care organizations, and educational institutions.
2. The purpose of any research conducted is to enhance understanding of issues affecting the community and to benefit the community either by increasing knowledge or by promoting change.
3. Community-based research projects must be consistent with the overall objectives of the urban research center.
4. Community-based research is conducted according to the norms of partnership: mutual respect; recognition of the knowledge, expertise, and resource capacities of the participants in the process; and open communication.
5. Representatives to the URC partnership are involved as appropriate in all phases of the research process (e.g., defining the problem; developing the data collection plan; gathering data; using the results; interpreting, sharing, and disseminating the results; and developing, implementing, and evaluating plans of action to address issues identified by the research).
6. Whenever possible, community members analyze and report data.
7. Community-based research projects produce, interpret, and disseminate the findings to the community in clear language respectful to the community and in ways that will be useful for developing plans that will benefit the community.
8. Community-based research projects follow the policies set forth by the urban research center regarding ownership of data and output of the research.
9. All research projects must adhere to the human subjects review process.

[a]Adapted from principles of collaboration developed by the Detroit, New York City, and Seattle URCs.

The Seattle URC developed its community collaboration principles by drawing on findings from earlier formative research, the Community Interview Project.[27] They conducted qualitative interviews with 85 community leaders, concerned citizens, community-based organizational staff, health department investigators, and academic research staff to examine the legacy of distrust between local communities of color and institutionally affiliated researchers. The principles guide the board, for example, in evaluating requests from researchers for letters of support or proposals for affiliated projects. In such cases, board members ask a series of questions derived from the principles to assess whether the proposed project is in compliance. If so, a letter of support is often sent; if not, the board proposes changes to make the project more congruent with the principles.

The principles of collaboration defined by the New York City URC were adapted from those outlined in Detroit. They have been used to guide the board in determining when and how activities benefit the local community. For example, when planning a national conference on asthma control in urban communities, the board decided to invite local asthma advocates and parents of asthmatic children, as well as researchers and clinicians. Referring to agreements outlined in the principles, the board successfully advocated for resources to support community participation in the conference, thus attracting both academic and community partners.

Setting Research Priorities

After establishing boards and defining principles of collaboration, each URC set local research priorities. During the first year of operation, the Detroit URC board reviewed local health issues to assess their amenability to intervention. With the overall goal of improving family and community health using a framework focused on the influence of social factors on health, 3 priority areas were identified by board consensus: access to high-quality health care, environmental health concerns for children, and violence prevention.

In Seattle, a broad spectrum of health concerns was eventually narrowed to 2 priority areas: economic development and ensuring community interests in research. Economic development was later broadened to research on social factors related to health. The priority of ensuring community interests was selected as a framework within which all research would be conducted.

On the basis of a review of 17 previous needs assessments conducted by academic researchers and community organizations, the New York City URC identified injection drug use, HIV infection, hepatitis C, and childhood asthma as research priorities. These priorities were later confirmed through consultations with community coalitions, community organizations, and residents.

Securing Resources

In addition to establishing well-defined governance processes, developing norms of partnership, and defining research priorities, all URCs secured additional resources to support their activities. The ability of the URCs to obtain human, financial, and other resources (e.g., office space) was critical to the development of their research programs.

Core CDC funds awarded to each of the URCs in phase 1, 1995 to 1999, ranged from no funds to slightly more than $500 000 per year. The Detroit and Seattle URCs used their initial core funds to support infrastructure development and maintenance, including hiring personnel to facilitate communication and other activities vital to establishing and maintaining the URCs, as well as conducting small-scale demonstration projects. After receiving core CDC funding in 1999, the New York City URC conducted similar activities and subsequently reported significant growth in terms of its ability to implement CBPR processes and activities. All groups used core funds to identify and obtain additional resources needed to further develop and enhance URC research programs. Financial awards were obtained from local and national foundations, as well as from local, state, and federal agencies.

INTERMEDIATE OUTCOMES

From the implementation of these activities, all URCs successfully developed community-based partnerships, developed trust within the partnerships, established public health research programs, and increased community and institutional capacity to conduct CBPR.

Community-Based Partnerships

With core funds from CDC and local resources, each of the URCs reported significant progress in building multisectoral partnerships. Each URC identified relevant partners who, despite initial wariness by some, committed to the partnership. These partnerships are now conducting a wide array of public health research activities based on local community priorities (Table 3).

Trust Within the URC Partnerships

URC partners repeatedly emphasized that time, patience, commitment, and willingness to compromise were necessary for growing trust and building partnerships. Partners also stressed the importance of the CBPR approach in the research undertaken by the URCs, as voted by 1 community partner: "I don't say we're doing it [CBPR] 100%, but the theory behind that, of getting the community's involvement and leadership in doing some of these projects, is really important."

Some Detroit URC board members from community organizations were initially distrustful about "what the University was up to this time" but accepted the invitation to participate with an "open mind" or in a "gatekeeper role" to ensure that URC research would address community interests. By 1999, community board members described the partnership as "cohesive" and "strong," attributing success in building a team of "partners with equal voices" (not just "research subjects") to the early development of procedures and principles to guide the process.[23] Board members also noted that once developed, trust requires ongoing attention. Time invested in laying the foundation and nurturing the partnership was viewed as indispensable to the success of the Detroit URC.

Early success in seeking and receiving funding for Detroit URC projects was viewed as strengthening the partnership because of the clear association between effort and outcome, particularly when funding for some projects was awarded directly to community-based organizations.

Seattle community members were skeptical that institutionally affiliated researchers

TABLE 3—Urban Research Center (URC) Research and Related Activities: 1995–1999

URC	Priority Areas	Topic Areas of Funded Projects	Funding Secured During 1995–1999	Dissemination
Detroit	· Access to quality health care · Environmental health issues for children · Violence prevention	· Maternal and child health promotion through village health workers · Domestic violence prevention for Latinas · Culturally appropriate consumer advocacy for Medicaid/managed care enrollees · Enrollment of uninsured children in Medicaid · Childhood asthma risk assessment, prevention, and control · Diabetes and cardiovascular disease prevention and control	$8 million	9 publications; 39 presentations
New York City	· Substance abuse · Infectious diseases · Environmental health	· Hepatitis B intervention and research · Problems of young injection drug users · Control of childhood asthma · In utero exposures and health disorders in later life · HIV prevention methods for women	$14 million	12 publications; 14 presentations
Seattle	· Economic development · Social determinants of health · Ensuring community interests	· Community experience of research · Immunization in seniors · Asthma prevention and control · Social determinants of health · Welfare reform evaluation · Child development program evaluation · Computer technology center evaluation · Domestic violence prevention for immigrant and refugee women · Community indicators of health assessment	$2 million	7 publications; 18 presentations

would be motivated to build true partnerships responsive to community needs. As with the Detroit URC, the development of procedures and principles was critical to building trust among Seattle partners. According to 1 community partner, "This last year, when we met it was more like we are all in this together. Let's help one another; let's share. It was really kind of a camaraderie, a supportive environment. It's taken us 3 years to get there, but we're here though." Partners in Seattle recognized that once built, the partnership needs continued attention (e.g., periodic review of the principles of collaboration) to reinforce trust and maintain true collaboration. They also identified a relationship between trust and efficiency—that is, as trust grows, "we get more done."

Trust building was also an issue in New York City. The New York City board inherited a research portfolio previously developed by researchers. Because of past disappointments with research conducted in East Harlem, community participants expressed a "wait-and-see" attitude. One community board member asked, "How is the research going to be helpful to this community? That's a question I have. I'm eager to see how it is going to benefit the community." Conversely, some community board members gave credit to the researchers for their willingness to change. One said that the New York City URC researchers "are at a point now where they realize that they cannot survive without the community, and they are making overt efforts to be involved and to gain credibility, not professional legitimacy, but qualitative credibility in the East Harlem community."

Public Health Research Programs

In the early stages of development, each URC spent several months defining research priorities that would reflect the interests of the researchers and the needs of their respective communities. After this, the boards and URC staff pursued funding for research projects and activities to address these priorities. In their first phase, 1995 to 1999, the 3 URCs collectively acquired $24 million in addition to core funding, initiated 20 community-based intervention and research projects, published 11 peer-reviewed articles on URC activities in their communities, and made numerous presentations at local and national meetings (Table 3). Descriptions of URC research activities have been published elsewhere.[2,3,23–25,28–58]

Increased Community and Institutional Capacity to Conduct CBPR

Each URC reported increased community and institutional capacity to conduct CBPR resulting from partnership activities. For example, previously unaffiliated community organizations forged new alliances across ethnic, cultural, and geographic boundaries. Also, funding for some URC projects went directly to community-based organizations rather than to research or public health host institutions. Community partners in New York City credited the URC partnership with providing increased opportunities for their organizations, including access to URC staff and other resources, a Web site with data on East Harlem, assistance with fundraising, and technical assistance with studies generated by community-based organizations.

University researchers noted that participation in URC activities and involvement in

community-sponsored events increased their capacity to conduct CBPR and improved university–community relations. Involvement in the URC partnerships led to an increase in the number of university faculty members committed both to the local URC and to the inclusion of CBPR theory and methods in public health research and teaching. The URCs also provided opportunities for students and postdoctoral fellows. For example, in Detroit, more than 30 graduate students worked on URC-affiliated projects that provided applied CBPR experience, and 3 doctoral dissertations based on URC-related research activities were completed. Partners from public health agencies noted an increase in their own commitment to work with local communities resulting from participation in a URC.

CHALLENGES

The URCs tackled multiple challenges, including balancing power among partners, forming trusting relationships, overcoming damage done by previous researchers (e.g., agreements not kept or abandonment after getting the data), acquiring adequate resources, developing and implementing complex interventions and evaluations, and waiting to see results. Larger societal issues (e.g., racism) presented additional challenges. Particularly noteworthy challenges across all 3 URCs were constraints on time, access to and distribution of funding, and confrontation of institutional racism.

Time

Fundamental to CBPR is that most, if not all, decisions are made in consultation with all partners. From broad decisions regarding which health priorities to pursue to specifics such as the wording of a survey question, decisions are made with a high level of partner participation. As noted by one community partner, "When steering committee members want to do something that might jeopardize the integrity of the science, you need discussion. It takes an incredible amount of time, but structure and process has ensured, to the extent possible, having community input every step of the way." Sometimes this process made it difficult to respond to public health or research imperatives in a timely way.

Although members of all URCs reported frustration with the time needed to obtain consensus or make a decision, most agreed that carrying out participatory processes usually resulted in solutions created by all partners. In some cases these solutions strengthened researchers' ability to answer scientific questions (e.g., increased recruitment and retention in studies or the use of culturally sensitive language). When externally imposed deadlines precluded full participation in the decisionmaking process, board members expressed frustration and even anger. Such situations posed a direct challenge to following the principles of collaboration.

URC partners also mentioned the additional time needed to observe changes in urban health and community conditions. Typically, project and funding periods are too short to accommodate these time requirements. One board member representing the community expressed the incongruity between expectation and reality: "I think that it is important for the [funder] to recognize . . . not to send money and a year later expect to hear we're doing all these wonderful community-based [health projects]."

Time is an especially scarce commodity for community board members with competing responsibilities. The demands of a URC board can be overwhelming to community members who have full-time jobs and other commitments. As noted by one community member, "Time invested in the URC is time away from solving other needs in their organizations and communities." URC academic researchers noted that the additional time needed to participate in CBPR projects is not considered in most review and promotion processes, thereby making CBPR less attractive to early career researchers experiencing the pressures of "publish or perish."

Funding

The Detroit and Seattle URC boards created their respective research budgets and allocated resources for URC activities, providing board members with details about the size and distribution of their budgets. Community board members expressed frustration with budgets inadequate to achieve community-level change and with control of funds by traditional research institutions instead of community-based organizations. Some board members representing the community questioned overhead costs associated with the host institutions and the resulting reduction of money available for capacity-building and prevention activities in the communities. Several board members expressed concern about dependency of core URC operations on noncategorical (e.g., non–disease-specific) funding from the CDC, suggesting that the URCs should obtain several sources for core funding to increase the possibility of sustainability.

Institutional Racism

Each of the URCs reported struggling with—rather than "sweeping under the rug"—issues related to institutional racism. Institutional racism has been defined as "differential access to the goods, services, and opportunities of society by race," or, more subtly, as "inaction in the face of need."[59] Data from all 3 URCs documented long histories of White researchers conducting researcher-driven investigations among local communities of color. Community partners noted that such research reproduced power imbalances in terms of identifying community concerns, decisionmaking, and resource sharing. Reflecting this sentiment, some community board members of color stated that the only reason they accepted the invitations to participate in URC development was to protect their communities from the researchers and to ensure that communities would benefit from the investigations (e.g., there would be action in the face of need). Community members at all 3 sites suggested that institutional racism can be addressed in part by increasing the number of public health researchers of color, increasing opportunities for community partners to participate equally in research, and developing training programs in CBPR for public health professionals. Also, across the 3 sites, board members expressed concern over a particular manifestation of institutional racism: access to and distribution of resources. Specifically, community board members were frustrated with how funding flows from the CDC and other funders to traditionally White host institutions.

DISCUSSION

Challenges to conducting CBPR are well documented.[6–15,19,20] The wide array of challenges cited in the literature may discourage funders, researchers, and community members from engaging in this type of research. The experiences of the URCs suggest that these challenges can be met and that CBPR can be implemented in diverse settings. However, partnerships are relationships that require will, skill, and ongoing attention. The early accomplishments described here demonstrate that the URCs have succeeded both by traditional academic and organizational standards (e.g., grants and publications) and by community standards (e.g., bringing new resources into the area and recognizing and incorporating the knowledge of community members into the research).

The following were key to the successful development of these partnerships: developing decisionmaking processes, defining principles of collaboration, setting priorities, and gaining access to resources. Variations in how these activities were made operational reflect differences among the URCs, including differences in host institutions, local history of community research, initial level of core funding, and racial and ethnic composition of the 3 urban settings. Despite such contextual differences, common processes across the sites emerged as critical building blocks.

The URCs' experiences confirm that CBPR is time intensive. Building equitable partnerships is an educational process for all participants: Communities learn to examine local problems from a research perspective, and researchers learn to approach public health problems from the perspectives of the people who live in the community. This joint educational endeavor takes time, which funding institutions should consider when making awards (e.g., providing 1- or 2-year planning grants for the development of partnerships before project creation and implementation).

The legacy of racism continues to shape the hierarchy of power in research partnerships. Funders, researchers, and agency heads are usually White with advanced educational degrees; community partners are usually people of color and often have less formal education, which can hinder understanding and appreciation of their contributions to the research by other partners. The challenge of community-based research partnerships is to overcome historical breaches of trust and discrepancies in power to build relationships across boundaries of race and class.

To our knowledge, validated instruments for measuring trust between community and research partners do not exist. Determinations of the presence of trust were based on statements from partners and on evidence that some initially distrustful partners came to the table and stayed. Although each URC reported successful development and maintenance of trust among partners, trust could not be assumed; rather, trust had to be seeded and nurtured to overcome the negative legacy of research conducted "on" rather than "with" communities.[4,60–63] Moreover, the meaning of *partnership* had to be reframed, from community-as-advisor or community-as-consultant to community-as-full-partner in all phases of research.

The promotion of shared power within partnerships includes ensuring the equitable distribution of resources. If mutual responsibility and shared control are goals of CBPR, then money, arguably the most powerful resource, also must be shared. Investing in community-based organizations increases the probability that community organizations will compete successfully for future awards and that effective interventions will be sustainable in their communities. The challenge of programs such as the URCs is to make clear to funders and policymakers that CBPR is a key strategy for incorporating local knowledge and resources into scientifically sound research on complex public health problems. Attending to issues of power sharing, variations in educational experiences, and the distribution of resources such as time and money is critical if CBPR is to realize its potential in redressing historically exploitative research.

CONCLUSIONS

In 1988 the Institute of Medicine stated that the mission of public health is to ensure the conditions—namely, policies, practices, and programs—under which people can be healthy.[64] In a 1996 update, the Institute of Medicine specified the development of partnerships among community, public health, and other partners as essential to achieving this mission.[65] With their focus on building trust between communities and other partners and confronting issues of racism, the URCs can be considered not only successful but also indeed essential to conducting public health research to improve health outcomes in these 3 communities.

Empowered communities, in concert with academic and public health partners, increase the probability that creating the conditions under which people can be healthy is achievable. "The backbone of our success," observed 1 community partner, "is that they [researchers] actually listen to the URC and to the community. Having community involvement has added to the effectiveness of URC projects. Having this extent of community involvement has led to the validity and success of the research projects." ■

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M. Metzler synthesized study analyses and led the writing of the manuscript. D. Higgins conceived of the study and supervised all aspects of its implementation. C. Beeker, N. Freudenberg, P. Lantz, K. Senturia, A. Eisinger, and E. Viruell-Fuentes assisted with the study, analyses, and writing. B. Gheisar, A. Palermo, and D. Softley provided valuable community perspective to all aspects of the study, helped to interpret findings, and reviewed drafts of the manuscript.

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For updated information on the projects, see these URC Web sites: http://www.sph.umich.edu/urc; http://www.seattlepartners.org; http://www.nyam.org/divisions/urbanepi/index.shtml.

Human Participation Protection

This research was approved by each participating organization's institutional review board. The Centers for Disease Control and Prevention institutional review board determined that review was unnecessary.

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